

# WELCOME

## PATIENT INFORMATION

Date _____	Home Phone _____
Name _____ MI _____	Work Phone _____
Nickname _____	Cell Phone _____
Birthdate _____ <input type="checkbox"/> Male <input type="checkbox"/> Female	Employer/School _____
Address _____	<input type="checkbox"/> Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Student <input type="checkbox"/> Retired
City _____	Spouse's Name _____
State _____ Zip _____	Spouse's Birthdate _____
Social Security # _____	Spouse's SS# _____
E-Mail _____	Spouse's Employer _____
<input type="checkbox"/> Minor <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed	
<input type="checkbox"/> Legally Separated <input type="checkbox"/> Divorced	
If minor, name of parent(s)/guardian(s) _____	

## PERSON RESPONSIBLE FOR ACCOUNT

<input type="checkbox"/> Same as Patient	<input type="checkbox"/> Other than Patient (Please complete info below)
Name _____	Employer _____
Birthdate _____	Daytime Phone _____
Address _____	Relationship to Patient _____
State _____ Zip _____	

## CASH PAYMENT

We offer a time of service discount on examinations and diagnostic procedures **if paid on the day of service** (does not include Optomap or contact lens service fee). This represents the savings in time and resources to us for not becoming involved in billing you or an insurance company.

I have read and prefer this option

## VISION INSURANCE

## MEDICAL INSURANCE

Insurance Co. _____	Insurance Co. _____
ID # _____	ID # _____
Group # _____ Birthdate _____	Group # _____ Birthdate _____
Subscriber _____	Subscriber _____
Relationship to Patient _____	Relationship to Patient _____

## IS PATIENT COVERED BY ANOTHER INSURANCE?

<input type="checkbox"/> Yes <input type="checkbox"/> No
Insurance Co. _____
ID # _____
Group # _____
Subscriber _____
Relationship to Patient _____

IF YOU ARE NEW TO OUR OFFICE, WHOM MAY WE THANK FOR REFERRING YOU? \_\_\_\_\_

IF NOT REFERRED, HOW DID YOU SELECT OUR OFFICE?  Insurance Company  Community Directory  Marketing Flyer  
 Splash  Sign/Building  Yellow Pages  Our Website

## Assignment and Release

I certify that I, and/or my dependents have insurance with the above named insurance company(ies) and assign directly to Liberty Lake EyeCare Center, P.S., Dr. Ulrich, and/or Dr. Garn all insurance benefits, if any, otherwise payable to me for services rendered. **I understand that I am financially responsible for all charges whether or not paid by insurance.** I authorize the use of my signature on all insurance submissions. Dr. Ulrich and Dr. Garn may use my health care information and may disclose such information to the above-named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

Signed \_\_\_\_\_ Date \_\_\_\_\_